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DELIVERY OF PSYCHIATRIC CARE TO THOSE MENTALLY ILL IN IRELAND PROPOSALS FOR CHANGE

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1 INTRODUCTION

A working group was set up by the Minister for Health, Mrs Eileen Desmond TD in October 1981 "to examine the main components, both institutional and community, of the psychiatric services, to assess the existing services, to clarify their objectives and to draw up planning guidelines for future development of the service with due regard to cost implications, to carry out such studies and to take part in such consultations as are necessary to assist this examination" In December 1984 the group's report entitled "Psychiatric Services - Planning for the Future" was presented to the Minister for Health, Barry Desmond TD

It will be the purpose of this paper briefly to describe the historical background leading to the setting up of the study group and to synthesise its main recommendations and the constraints on their implementation

2 HISTORICAL ASPECTS OF THE CARE OF THE MENTALLY ILL IN IRELAND

The provision of care for the mentally ill in any organised fashion and on any substantial scale belongs to the period 1750 - 1850 in the Western world It is clear that mental illness and sub-normality of intelligence were recognised in antiquity but the organisation of care, protection and treatment for these as groups of people did not emerge until modern times

The reasons why this should be so are not readily apparent but it seems likely that the very substantial increase in life expectation which followed improved nutrition and consequent resistance to the major infectious diseases may have differentially affected the mentally ill compared with the mentally normal It is quite likely that prior to this time and these improved conditions, the mentally ill, or those about to become mentally ill, had a much higher mortality than those not so affected and so insufficient numbers of them survived into adult life to constitute a social problem as defined in the modern sense In addition

from the middle ages until well into the 18th century, the perception of "public health" may have been much more concerned with survival than with the quality of life itself Under these conditions mental illness did not rate highly as a condition for which provision needed to be made This situation may still be the case today in some third world countries where mortality from famine and infectious diseases is so rampant that considerations of the quality of life seem to be remote and irrelevant There are commentators who try to impart the view that major mental illness increased dramatically around the turn of the 19th century and that it was this rather than increased social visibility of the impairment resulting from mental disorder that led to the increased provision of services which so characterised the 19th century Unfortunately the evidence to support this case is not particularly impressive and the issue may ultimately be incapable of resolution because of data deficiencies

Mental illness like illegitimacy, was a particular inconvenience for those with property to pass on to their descendants Lunacy, like bastardy, had an unhappy knack of dissipating inherited wealth and so it is perhaps no surprise to find that private mad-houses preceded public lunatic asylums In the early to mid-eighteenth century a number of private mad-houses were established to cater for the lunatic wealthy However, it wasn't until the nineteenth century that the question of the lunatic poor became a live social issue In the early decades of that century numerous commissions were set up to assist administrators and to advise on policy decisions in relation to an inconveniently growing problem These initiatives culminated in, first, the provision of limited accommodation for the mentally ill and, secondly, in a piece of major legislation, The Lunacy (Ireland) Act 1821 which empowered (but did not oblige) local authorities to provide appropriate accommodation for those mentally ill It was under this legislation that most of the public lunatic asylums or, mental hospitals as they were to become, were built The consequence was that lunatic asylums were provided on a district basis throughout Ireland They were built in three phases, the first group were built between 1825 and 1835 in an attractive classical style which was provided by the architects of the Board of Works of the day These were in Armagh, Limerick, Derry, Belfast, Carlow, Portlaoise, Ballinasloe, Clonmel and Waterford In 1846 the office of Inspector of Lunacy was set up and the Inspector was obliged to present a report to the Lord-Lieutenant on the state of lunacy in Ireland From the very earliest days a continuous refrain appeared in the Inspectors' reports This was to the effect that the prevalence of lunacy in the country was far out-stripping the residential resources specifically supplied for it In response, a second wave of asylum building took place between 1852 and 1855, again commissioned by the Board of Public Works but not necessarily carried out by its architects The new asylums were in Kilkenny, Carlow, Cork, Omagh, Mullingar and Sligo All of these were in the Gothic style and, in distinction to the earlier classical buildings, were on three stories and provided accommodation in dormitories rather than in single cells A third wave of

asylum building, again in response to the Inspectors' perceived deficiency of asylum places in the face of increasing mental illness, took place between 1865 and 1869 Thus 6 more asylums were built at Downpatrick, Letterkenny, Castlebar, Ennis, Enniscorthy and Monaghan These had no fixed architectural style and were more individualistic therefore than their predecessors It was at the end of the century that legislation made it possible to erect auxiliary accommodation to existing lunatic asylums Thus the Portrane Asylum was added in the 1890's as an adjunct to the Grangegorman Hospital or Richmond District Lunatic Asylum as it was known

The last purpose-built mental hospital to be opened in this country, and the only one in this century, was at St Brigids, Ardee and that was in 1933 Following World War Two and, curiously in the face of a decline in mortality from pulmonary tuberculosis and in the incidence of the condition, a gigantic building plan of sanatoria, had been undertaken These redundant buildings, some of which were never filled with the tuberculous, were, in certain cases, made available to the psychiatric services - not one feels because of any concern for mental illness but because of lack of alternative usage

As soon as lunatic asylums or mental hospitals were made available to the public they were filled and by 1958 approximately 21,000 or 0 7% of the population of the 26 counties was to be found in mental hospitals Some hospitals contained over 2,000 patients there was considerable over-crowding with individual wards containing in many cases well over 100 patients and physical conditions within hospitals were quite unsatisfactory There was little by way of alternative to hospitalisation if one became mentally ill and out-patient services hardly existed until the 1950 s Untill 1945 and the appearance of the Mental Treatment Act, it was not possible voluntarily to seek treatment for mental illness and one could enter a mental hospital only by being certified there into

The recruitment of suitable medical staff to psychiatric hospitals was a considerable problem as psychiatry was not seen as a prestigious branch of medical practice With the passage of time the mental hospitals became highly artificial, institutionalised premises with a high degree of self-sufficiency All the material needs of inmates were supplied from within the asylum walls and all asylums had large farms so that they were self-sufficient from the point of view of food An asylum was an important part of the socio-economic fabric of local communities and in many towns virtually the only large employer Jobs as attendants or other ranks within the asylum were avidly sought and handed down within families from generation to generation

3 DISQUIET AND REALISATION THAT CHANGE WAS NECESSARY

Despite the apparent complacency which had settled over the asylum system for most of the twentieth century there was a growing perception that conditions within asylums were far from satisfactory and an awareness that

elsewhere i e in Britain, and in the better services in the United States, alternatives existed to in-patient treatment and that new and potent drugs were becoming available to treat mental illness Furthermore comparisons of the numbers of persons in Irish psychiatric hospitals per head of population with other countries showed Ireland as emerging in a distinctly unfavourable light (and still do)

Table 1 Hospital beds per 1,000 population in different areas (1961 or nearest available year)

Country	Total number of hospital beds per 1,000 population	Number of psychiatric beds per 1,000 population
Ireland*	21 4	7 3
Northern Ireland	11 9	4 5
England and Wales	10 4	4 6
Scotland	12 3	4 3
France	13 4	2 1
West Germany †	10 6	1 7
Spain	4 4	1 1
Portugal	5 3	0 9
Italy	9 3	2 2
Netherlands	7 6	2 3
Denmark ‡	10 0	2 2
Belgium	8 0	3 1
Norway	10 6	2 9
Sweden	15 9	4 8
Finland	9 2	3 6
USA	9 1	4 3
New Zealand	11 6	3 5
Canada	11 1	3 9
Australia	11 0	3 1
USSR	8 5	0 8
Japan	9 5	1 1

* Excluding Northern Ireland

† Including West Berlin

‡ Including Faroe Islands

Table 2 Hospitalisation rates in different areas

	Hospitalisation rates per 100,000	
England	171	(1978)
France	228	(1978)
Denmark	166	(1982)
Ireland	415	(1981)

The result of this was the setting up in 1961 of The Commission of Enquiry on Mental Illness which was, broadly, charged with examining the current situation in relation to services available for the mentally ill and making recommendations for the improvement of these services

Briefly the Commission recommended that patient care, particularly short-term residential care should be given in psychiatric units situated in general hospitals Also recommended was an extensive network of rehabilitation services for long-stay patients The Commission naively believed that with the implementation of these two main recommendations and the development of extensive community services, by 15 years time from the date of the publication of the report in 1966, the number of beds in the psychiatric service would have fallen to 8,000 The Commission also recommended an expansion in the type of personnel employed in psychiatric services so that they should include psychologists, social workers, occupational therapists and others whose skills were needed and appropriate Finally the Commission recommended that research be undertaken into treatment and into the efficacy of different forms of care and into causes and methods of prevention of mental illness

In the event the recommendations of the Commission, which were on the whole excellent, were with some exceptions, not implemented As a consequence, 15 years later, in 1981, the number of in-patients had not fallen to the 8,000 envisaged by the Commission but stood resolutely at twice that number It was in this setting and background that a Study Group on the future of the psychiatric services was set up by the Minister for Health Ms Eileen Desmond in 1981 Not surprisingly, perhaps, the recommendations from the group, entitled Planning for the Future, of 1984, were not that very dissimilar from those of the Commission in 1966

4 RESUME OF MAIN RECOMMENDATIONS OF PLANNING FOR THE FUTURE

Planning for the Future envisages that care for the mentally ill demands that a comprehensive service be provided for the target group A range of community-based facilities will replace the present institutional care in psychiatric hospitals and in in-patient care where necessary will be provide in small units of approximately 30 - 40 beds located in general hospitals Notwithstanding the need for comprehensiveness of service and the provision of in-patient care, Planning for the Future recognises that the least restricting and least dependence-creating form of care appropriate for each individual must be provided Thus where at all possible community care is seen as preferable to institutional care

Within the psychiatric service itself, continuity of care is seen as being paramount and this means that the same team of professionals, co-ordinating with primary medical care and the primary carers, provides care at all levels from in-patient to community residence, for all illnesses and for all stages of illness The simplest and most effective way of doing this is by providing a "sectorised" service This concept derives from French psychiatry and is concerned with dividing geographical populations into manageable sizes, numerically and topographically, and allocating a professional team to each sector to ensure continuity of care across people, across services and across illnesses The size of the sector, the Study Group envisaged, would be of the order of 25 to 30,000 population Planning for the Future stressed the importance of the multi-disciplinary approach to the organisation of care delivery This principle recognises that since psychiatric illness handicaps in a variety of different functional areas, such as work, social relationships etc , so that skills of many different disciplines are needed to reduce handicap from established psychiatric disorder These skills must be provided on an integrated basis so that maximal effort is brought to bear on the rehabilitation of sufferers

5 PLANNING AND IMPLEMENTATION

Recognising that the major reason for the non-implementation of the recommendations of the report of the Commission of Enquiry on Mental Illness was the lack of any attempt to translate paper recommendations into practical happenings Planning for the Future felt that appropriate mechanisms were necessary, both centrally and locally, to ensure that its recommendations were progressed For this reason the report "requires that each Health Board draws up a realistic plan which will determine how the various parts of the service will inter-relate and the time scale for action,

- identify the policy and objectives of the service,
- assemble the relevant information,

- draw up a plan of action for the specified time scale,
- implement the components of the plan in appropriate sequence,
- monitor progress in drawing up and implementing the plans,
- evaluate the benefits being achieved "

To enable all this to happen Planning for the Future recommended organisation of local management bodies below the Health Board level These would be the catchment area management committee, and at a more intimate level, the hospital management team This three-staged administrative organisation would be the means by which policy and its implementation, its monitoring and its evaluation would be effected

In this process certain key issues were identified as being of paramount importance The first relates to *admission policies* This recognises that one of the major problems confronting our over-institutionalised psychiatric service was the indiscriminate and inappropriate admission of many patients whose illness does not require in-patient treatment and for whom non-hospital alternatives are more appropriate Given an almost unlimited and elastic supply of admission beds it seems impossible to gain control of the present situation unless some limits are set to the admission of patients This can best be achieved by rationing the supply of admission beds or alternatively and coincidentally, the setting up of rigid admission guidelines Secondly, Health Boards and individual services were asked to examine their need for community alternatives to in-patient care, in particular community residences of domestic scale where suitable patients reside with minimal supervision from the psychiatric team, hostels containing up to 15 people where high support facilities are available, that is to say where 24 hour nursing cover can be provided, day facilities such as day-hospitals and day-centres where treatment rehabilitation and training can be undertaken particularly of existing long stay institutionalised patients and of those living in community residences

Coincident and interdependent on this was the policy of *rehabilitation* leading to eventual discharge to independent community living of current long stay psychiatric hospital residents

A further consideration which hospitals were asked to address was the problem of the numbers of primarily *mentally handicapped,* as distinct from mentally ill, persons in residential care About 16% of psychiatric hospital residents are there not because they are mentally ill, but because they are mentally handicapped and these 2,000 - 2,500 persons are inappropriately placed in psychiatric hospitals The possibility of separating them from the psychiatric in-patient population and dealing with them separately in each hospital or, better still, working with the local specialised mental handicap agencies to place them appropriately in specialised facilities is seen as a necessity

A further question to be addressed by Health Boards and hospital services was the question of *the elderly* Irish psychiatric hospital populations are increasingly growing old Currently 35% of psychiatric residents are 65 and over and in many hospitals the percentage is much higher than this The resettlement needs of such people out of psychiatric hospitals are obviously different than those of younger people and the obligation to provide specialised facilities for them is something that Health Boards were asked to consider

The matter of *alcohol-related problems* was also one which was discussed by the Study Group and one which Health Boards were asked to address not least because of the considerable number of admissions to psychiatric hospitals of people with this condition Approximately one third of male and one quarter of admissions for both sexes are for this problem In general Health Boards were asked to examine the matter as it affected their own service and, in particular, to consider alternatives to the excessive demands on in-patient care which this group is currently making

Health Boards were asked to submit plans to the Department for their own individual services including an assessment of the suitability of existing long-stay patients for rehabilitation towards deinstitutionalisation and in particular to indicate the quantitative nature of this potential within each service At the same time the Department set up an implementation group from within its own resources who are meeting with individual health groups to discuss their implementation plans as submitted to the Department and, most importantly jointly to consider the financial implementations of such developments

6 THE COST OF IT ALL

One of the most often repeated criticism of Planning for the Future is that the finance necessary to implement the movement from institution to community will not be forthcoming There are those who would maintain that community alternatives will be much more expensive than institutional care No one however did a serious costing exercise on the matter It must be pointed out however, that those psychiatric services which are largely community-based are cheaper than those which are mainly institutionally based, thus the St Lomans Dublin service has a bed allocation per head of thousand of population of less than 0 5 and the cost of running the service, at 4 million per annum is approximately £15 per head of population per year This compares with cost of £70 per head of population per annum in Co Clare where the service is predominately institutional-based and provides 5 beds per thousand of population It is the crushing burden of institutional care which eats up man-power resources, mounting up to 80% of all revenue costs in psychiatric services Furthermore, there is the consideration that the maintenance of the fabric of buildings, which in most cases are over a century old, is substantial indeed and of doubtful long-term investment potential In comparison,

services in other countries have a much smaller institutional component, and the accompanying costs, are therefore much lower Indeed all the indications are that a community-based alternative will absorb much less manpower and the revenue costs will therefore decline substantially

The capital costs involved with the provision of the structures necessary for a community-based approach are quite variable depending on whether premises are bought, rented or purpose-built Capital expenditures can be greatly reduced by the use of rented accommodation and housing authorities should be made to feel obliged, as they are by current legislation, to provide housing for persons currently living in psychiatric hospitals on the grounds that such accommodation is not home and hospital residents are therefore homeless In fact this has happened in many services and these houses provided in an ordinary housing estate function well as domestic scale residences for 4 to 6 patients who require very little by way of supervision other than having the community psychiatric nurse look in once or twice a week Indeed in some cases these residents have become completely autonomous of the psychiatric service, have their own bank accounts, pay their own rents and look after the other services from their own financial resources These resources come from the social welfare benefits to which they are entitled and from whatever earnings they may have made for themselves from industrial or other work which they obtain, either in the workshops of day-centres of the psychiatric service or independently In relation to day-centres, similar rental arrangements for suitable premises may be entered into and, in fact, are done so by several Health Boards When it comes to high support hostels rental is not usually a feasible option, because of the size of premises required its location and its internal physical arrangements For this reason purchasing a suitable premises, usually a large house with space enough to accommodate up to 15 patients and staff and set in grounds of about a half to one acre or thereabouts is the most likely option Fortunately such houses are often readily available in the residential areas of towns and, in the current economic climate, are selling relatively cheaply The last option, the purpose building of structures for specific psychiatric use is probably the least attractive For one thing the whole site acquisition and planning process takes a very long time Secondly, relative to existing property, building costs are extremely high and finally the danger of purpose-building is that the purpose for which premises are currently constructed may soon become outmoded and out of date Indeed the trouble with our existing psychiatric accommodation is that most of it was purpose-built 100 - 150 years ago and is now totally unsuitable for present purposes

It may be then, that in relation to capital costs, some monies will be needed to provide structures in the community as alternatives to institutional care However, if maximal use of the rental facility is pursued, capital costs can be substantially reduced Nevertheless, it will still be necessary to purchase at least some houses suitable for high support hostels Here some resource

transfer may be possible in that many hospital's own farms comprise valuable land for development purposes which would realise substantial sums if sold The money realised should then be deployed towards funding community developments Notwithstanding, Planning for the Future had this to say about capital requirements "the total capital required to implement the recommendations of this report could be in the region of £50 million, spent over a period of 10 to 15 years While this is a substantial level of expenditure, we consider that there are compelling reasons why it should be committed If the psychiatric service is not developed along the lines indicated in this Report then the psychiatric hospitals will continue to accommodate a large number of patients Most of these hospitals date from the middle of the last century and are now approaching the end of their lifespan If they are to provide tolerable living accommodation for patients, an extensive programme to restructure and replace the existing stock of buildings must be undertaken This would require a much larger investment of capital funds than would be involved in implementing the recommendations of this Report If the existing hospital buildings were to be brought up to acceptable modern standards, or to be replaced where necessary with purpose-built in-patient units, the capital required could be in the region of £150 million"

The *revenue* resources are not seen as such a major problem as capital resources As it stands, the psychiatric services are over-subscribed from the revenue point of view, largely because of the enormous work force (there are 6 000 psychiatric nurses in the country) needed to sustain the massive institutional component The transfer of these resources from institution to community does not present any difficulty and in fact, leaves the service over-staffed In this regard negotiations on redundancy, early retirement etc have been in progress between the Department and the unions concerned

7 CONSTRAINTS ON IMPLEMENTATION

The recommendations of the Commission of Enquiry on Mental Illness were not put into effect What grounds are there for believing that those of Planning for the Future, which are materially the same, will not suffer the same fate? The answer to this is that now an implementation process has been set up for ongoing joint consultations between central and local health administrations - something that did not take place in 1966 Nevertheless it would be ingenuous to believe that this will necessarily result in a speedy implementation of the recommendations of Planning for the Future What are the obstacles?

Most people would say that they are financial I would disagree Our psychiatric service is heavily funded at the moment Currently approximately £200 million are spent on the psychiatric services annually In come cases as much as £13 million are being spent on psychiatric services for a population of 100 000 people It is clear that to say this represents under-funding is nonsensical It is simply the case that services are costing an enormous

amount of money We are evidently not getting good value for the resources given to psychiatric services Almost exclusively the reason for this is that these services are grossly over-institutionalised But we have to recognise that institutionalisation is a vested interest It requires manpower to maintain a large institution and its patients, more manpower than is required by community care of the same patients And because jobs are important in our current situation of high unemployment they are, therefore, protected by the unions involved and deinstitutionalisation will be resisted Notwithstanding currently discussion is taking place to ensure that the resulting redundancy likely to ensue when wards close and patients are discharged will be successfully negotiated

Despite the fact that community alternatives will almost certainly cost less than the current institutionalised service, the current cuts in health care expenditure proposed by central government may actually impede community development or be used to impede it The response of one Health Board to a reduction in its budgetary allocation has been to cut the community aspects of the psychiatric services while leaving untouched the notoriously unsatisfactory institutional component

Also worrying from this point of view is a discriminatory attitude towards psychiatric services compared to the rest of medical social services This is ubiquitous and basically it springs from public attitudes which are anti-pathetic towards the mentally ill It is reflected in central and local politics and there is an old saying that there are no votes in lunacy There is, therefore, a danger that in a time of financial recession and reduction in expenditure on health services, psychiatric services may suffer disproportionately Indeed in some cases this is more than an apprehension The commitment and will of professional personnel providing psychiatric services, be they management or professionals, to implement the recommendations for Planning for the Future are vital When these are lacking the implementation process becomes much more difficult In this regard it is important to acknowledge the reception given to Planning for the Future by various professional groups It is worth noting that all the professional bodies who commented on the report including the psychiatrists, felt affronted that they had not been approached for representation on Planning for the Future Nevertheless the policy document was greeted with what may best be described as "qualified approval' Translating "qualified approval into realistic practical action is of course another matter and the cynics might point to the lack of energy and dynamism in this regard of senior professional and administrators in the psychiatric service over many years and ask how much attitudes and practices will be transformed in a relatively short space of time It is a valid question and, more than anything else, the limiting element in the implementation process are the psychological sets and resistances of professional personnel in moving towards a de-institutionalised service It is the view of the Department of Health that this can be overcome only by consistent monitoring, and indeed,

accountability on the part of those involved There is no doubt that this is going to be a lengthy process but for those responsible or committed enough it can be achieved

Apart from those given above there are no major constraints which should hinder the implementation of Planning for the Future I have no doubt that popular community attitudes are not a relevant issue as, in my own service, St Lomans, Dublin, we have accomplished much by way of community residences, without any substantial or enduring opposition from local community groups I am therefore confident that this is not a serious obstacle to deinstitutionalisation

More important however as a constraint is the current unemployment situation The handicaps of psychiatric illness are compounded by external factors and one of these is unemployment Rehabilitation has as its ideal the return to optimal function of individual suffering from illness Optimal function necessarily embraces the capacity to work rewardingly and gainfully Unfortunately, even for many of those not handicapped, this is not now possible This is a very real constraint on the rehabilitation possibilities which we can offer individuals who have suffered from psychiatric illness Nevertheless some specialised work and some continued industrial, renumerated employment is still possible though falling far short of full open-employment

DISCUSSION

Eamonn O'Shea I should like to congratulate Dr Walsh for his fine paper on the history and proposals for change with respect to the delivery of psychiatric care to those mentally ill in Ireland It is altogether too seldom that explicit discussion is encouraged in relation to the cost and benefits of community and institutional options in this area Dr Walsh's paper provides a very useful framework for consideration of the main options

My comments are not meant to dampen enthusiasm with respect to the movement of care of patients into the community Rather it is my intention to highlight the pitfalls of proceeding as if all the evidence with regard to the superiority of community care is now in It is not the case that all the available empirical evaluation supports community care for psychiatric patients, indeed there is little evidence for Ireland of any comprehensive research with regard to the cost of formal and informal community care, the optimality of the current provision of community services, or the quality and outcomes associated with different regimes of care

Any proposal for change in the psychiatric services which are not firmly based on sound and comprehensive empirical evidence with regard to efficiency and effectiveness must be subjected to some criticism Dr Walsh makes the point that community services almost certainly cost less than the current

institutionalised service Yet the evidence is not at all clear especially when both formal and informal costs are considered and when outcome is included Watt considers that the movement towards community care rests on "unexamined contentious assumptions about the community, the family and nature of mental illness, its cause and treatment" In a recent article in the British Medical Journal Wilkinson and Pelosi argue that the most cost effective way to delivery mental health care is not clear

Much more information is required on the costs and benefits of community care for psychiatric patients in Ireland The relevant alternatives need to be explicitly specified Institutional psychiatric care can take many forms and may include many patients who are more properly specified as elderly or mentally handicapped Community care can also vary by form of care home care, sheltered accommodation, residential hostels, combinations of community care and institutional based day care facilities Even within the home households can vary by size, type and composition

Measurement of Costs

The measurement of costs in community care must relate to opportunities foregone which means that resources (marketed and non-marketed) are valued in terms of the payments they could command in their next best alternative use If a person moves from institutional care to ordinary housing accommodation a cost is incurred due to a dwelling now being occupied which could have been used for someone else Furthermore persons cared for in the community consume resources such as food, fuel, clothing, electricity, etc which they would not incur if being cared for in an institution Any valid comparison of community or psychiatric care must include housing and personal consumption costs for community patients

Total service costs for psychiatric community care are relatively straight-forward to enumerate and value Unit cost must however be developed for all services including day care, short stay and respite care An important resource in community care for psychiatric patients is the informal non-marketed care provided by family and friends Many commentators neglect such informal care as a valid cost element in community care Yet there is an opportunity cost involved Very often carers must give up paid work, leisure time is almost certainly foregone by almost all carers Few studies attempt to value such opportunity costs Yet not to value them is to implicitly assume away a real burden on carers and covertly transfer the burden of care from the state to family care

There is another dilemma in attempting to cost community care for psychiatric patients, namely whether to cost actual patterns of services received or to cost some ideal package that is deemed optimal by consumers and/or health professionals In the same way that the cost of care can be kept artificially low by not valuing informal care so too can the cost of care be reduced by

focusing entirely on actual provision even if the latter is deemed sub-optimal It is of course difficult to get agreement on optimality of community care provision, specific interest groups have their own ideas, often it must be said maximising subject to unrealistic budget constraints

Outcome Measurement

At the limit cost control implies no service at all A proper evaluation using the methodologies of economics and psychiatry must focus on inputs and outcomes The most serious problem relates to defining acceptable multi-dimensional measures of outcome It is possible to assess effectiveness and outcome in a uni-dimensional manner across criteria such as presence of symptoms, behavioural difficulties, social functioning and so on Yet combining these dimensions within a single measure of outcome is as Renshaw points out extremely difficult

Goldberg sees a value in separating what he terms "soft" non quantifiable costs and benefits from those that are inherently measurable and possible to value in monetary terms If a service produces more "soft" benefits and is less costly than it dominates the other alternative(s) If a service has more "soft" benefits but is more costly Goldberg argues that at the very least health planners have an objective data set to help them decide whether the extra quality is worth the extra cost Many studies overcome the outcome measurement problem by focusing an cost effectiveness analysis, homogeneity in quality and outcome is assumed across regimes of care This is hardly satisfactory, yet it does provide a basis for proceeding and at least makes explicit data available to policy makers who are still faced with difficult decisions, but, at least have the benefit of a more complete information set

Institutional Barriers to Change

Providers are reluctant to discharge patients into the community unless they feel an adequate community care service exists The provision of a comprehensive community care service requires resources which presumably under the present stringency in public expenditure cannot be provided until institutional services have been dismantled Unless some form of "seed capital" is available for community psychiatric services it is difficult to be optimistic about the quality of community care Perhaps the impasse could be overcome by the provision of loan finance by the exchequer to the Health Boards Funds for the repayment of such loans could be generated by the rent and/or sale of buildings currently used by institutionalised psychiatric patients

Any major change in the balance of psychiatric care arouses rather than diminishes professional interests more especially if existing hierarchial mechanisms of authority are under threat Most of the empirical work which has been done with regard to the economic evaluation of psychiatric care has focused on the use of nursing staff to provide therapies usually provided by

consultant psychiatrists Mangan and Ginsberg have indicated clinical and economic benefits from nurses treating patients with neurotic disorders in the community Mangan also reported that consumer satisfaction was significantly higher among community psychiatric nurse patients The whole question of professional autonomy is a much neglected area of research in the Irish health care system – yet inflexibilities and often legitimate concerns among providers may be inhibiting the re-organisation of care for psychiatric patients

In conclusion I have great pleasure in proposing a vote of thanks of the Society to Dr Walsh for his fine paper